

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-006427

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 149Primary Registration District No. 1002Registrar's No. 727

FILED FEB 18 1963

VS 300
Rev. 4/591
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DATE AMENDED

INSTEAD OF

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Ray	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Kansas City		c. CITY OR TOWN Lawson	
Length of stay in 1b 3 Weeks		Inside Limits Yes No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION Research Hospital		d. STREET ADDRESS (If outside, give location) 420 N. Raum	
3. NAME OF DECEASED (Type or print) First MINNIE Middle MAUDE Last CHEEK		4. DATE OF DEATH FEB. 3 1963	
5. SEX Female	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 9-14-1882
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY At home	
13a. FATHER'S NAME James M. Lane		13b. MOTHER'S MAIDEN NAME Martha M. Henderson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. [REDACTED]	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY) IMMEDIATE CAUSE (a) Cancer of the Thyroid		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)		20c. TIME OF INJURY Hour _____ a.m. _____ p.m. Month, Day, Year _____	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
20f. CITY, TOWN, OR LOCATION		COUNTY STATE	
21. I attended the deceased from Jan 20, 1963 to Feb 3, 1963 and last saw her alive on Feb 2, 1963 Death occurred at 8:16 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Don A. Black M.D.	
22b. ADDRESS 6400 Pleasant K.C. Mo.		22c. DATE SIGNED 2/3/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2-5-1963	
23c. NAME OF CEMETERY OR CREMATORY Lawson		23d. LOCATION (City, town, or county) (State) Lawson Missouri	
24. FUNERAL DIRECTOR Jarman Funeral Home, Lawson, Mo.		25. DATE RECD. BY LOCAL REG. 2-4-63	
26. REGISTRAR'S SIGNATURE Ruth Song			

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Lindell J. Jarmann

Licensed Embalmer No. 4589

P. O. Address Excelsior Springs, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.